U.S. Department of Labor

Office of Administrative Law Judges
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Issue date: 22Feb2002

In the Matter of	:	
	:	
ROY E. GREENE,	:	
Claimant,	:	
	:	
vs.	:	Case No. 2000-BLA-687
	:	
	:	
BULLION HOLLOW ENTERPRISES, INC.,	:	
TWO M COAL COMPANY,	:	
Employers,	:	
and	:	
	:	
DIRECTOR, OFFICE OF WORKERS'	:	
COMPENSATION PROGRAMS	:	
Party-in-Interest.	:	

Joseph E. Wolfe, Esq.
For the Claimant

H. Ashby Dickerson, Esq.
Sean B. Epstein, Esq.
For the Employers

BEFORE: EDWARD TERHUNE MILLER
Administrative Law Judge

DECISION AND ORDER - DENYING BENEFITS

Statement of the Case

This proceeding involves a first claim for benefits under the Black Lung Benefits Act, as amended, 30 U.S.C. 901 et seq. (hereinafter "the Act") and regulations promulgated thereunder.[1] Because the

[1] All applicable regulations which are cited are included in Title 20 of the Code of Federal Regulations, unless otherwise indicated, and are cited by part or section only. Director's Exhibits are indicated as "D-", Bullion Hollow's

Claimant was last employed in coal mine work in the state of Virginia, the law of the United States Court of Appeals for the Fourth Circuit controls. *See Shupe v. Director, OWCP*, 12 BLR 1-200, 1-202 (1989) (*en banc*). Since Claimant filed this application for benefits after January 1, 1982, Part 718 applies. Since the claim was pending on the effective date, January 19, 2001, of the December 20, 2000 amendments to Parts 718 and 725, consideration of the claim is governed by the amendments in accordance with their terms.

The instant claim was filed by the Claimant, Roy E. Greene, on June 21, 1999 (D-1). On October 26, 1999, the District Director awarded benefits (D-17). The named putative responsible operators, Two M Coal Company, Inc. ("Two M") and Bullion Hollow Enterprises, Inc. ("Bullion Hollow," the second employer) were notified of the initial finding, and Two M, filed a timely controversion on October 29, 1999 (D-17, 18, 20). On December 15, 1999, Two M filed a Motion to Dismiss Claim on Grounds of Abandonment pursuant to the Claimant's failure, without reasonable explanation, to attend a scheduled medical evaluation by Dr. Castle (D-22). Claimant responded, objecting to his medical evaluation by Dr. Castle, whom he alleged "has a tendency to use medical personnel that are not qualified/license[] to perform the Black Lung Testing." (D-24). By letter dated January 4, 2000, Two M, arguing that Claimant's allegations were unfounded, again requested that the case be dismissed on grounds of abandonment, and, in the alternative, requested that an order be issued compelling the Claimant to attend such an evaluation (D-25). Claimant responded on January 14, 2000, and agreed to submit to the medical evaluation if Two M, at the time of the evaluation, could arrange to have the license certificates of all those individuals involved in the evaluation available to the Claimant (D-26). On January 24, 2000, Two M agreed to Claimant's requested production of licenses and notified the Claimant that it would reschedule the evaluation (D-27).

On February 23, 2000, the District Director, having determined that Two M was the properly designated responsible operator, notified Two M of his initial determination that the Claimant was entitled to benefits under the Act and that it should begin payment of benefits within thirty days of the date of the letter (D-29, 31). Two M disagreed with the Director's determination and requested a hearing on March 2, 2000 (D-30). This claim was forwarded to the Office of Administrative Law Judges on April 18, 2000 (D-32).

A formal hearing was held in Abingdon, Virginia on December 20, 2000, at which all parties were afforded a full opportunity to present evidence and argument. At the hearing, Director's Exhibits one (1) through thirty-three (33), Bullion Hollow's Exhibits one (1) through thirty-three (33), and Two M's Exhibits one (1) through four (4) were admitted into the evidentiary record. (Tr. 13, 38, 42-43).

ISSUES

Exhibits are indicated as "EB-", Two M's Exhibits are indicated as "ET-", and Transcript of the Hearing is indicated as "Tr."

1. Whether the miner has coal workers' pneumoconiosis?
2. Whether the pneumoconiosis arose out of coal mine employment?
3. Whether the miner is totally disabled?
4. Whether Claimant has proved that he is totally disabled due to pneumoconiosis?

FINDINGS OF FACT, DISCUSSION, AND CONCLUSIONS OF LAW

Background

The Claimant, Roy E. Greene, was born on November 18, 1944, and has a seventh grade education (D-1, Tr. 32). Claimant married Debra Dean in August 1998 (D-1, 5). They were married at the time of the hearing, and, therefore, Claimant has one dependent for purposes of augmentation of benefits under the Act (Tr. 37, EB-15A at 3-6).

Claimant claimed thirty-three years of coal mine employment (D-1). The District Director found that Claimant had established 22.89 years of coal mine employment, and Two M agreed with, and stipulated to that finding (Tr. 14). This tribunal finds that the evidentiary record supports the Director's finding and the stipulation of 22.89 years of coal mine employment (see D-2, 3). Claimant's last job in the coal mines was as a "working foreman," a job he worked for ten years or more, and which he left in April 1996 after a back injury (Tr. 28, ET-1). As a working foreman, the Claimant had to crawl into areas and check for gas and ensure safety in the mine. He also did the fire bossing and filled in for other workers in positions such as roof bolter or continuous miner operator when necessary (Tr. 28, ET-1).

The evidence of record establishes that the Claimant began smoking in his early twenties and was still smoking during his medical examination by Dr. Dahhan on June 26, 2000. While Claimant's testimony regarding the length of his smoking history varied greatly, he consistently reported that when smoking regularly, he smoked approximately one-half pack of cigarettes per day. Claimant was fifty-five years old when Dr. Dahhan examined him, and, therefore, this tribunal finds that Claimant's smoking history was at least thirty-years in length at a rate of one-half pack per day. (Tr. 27, 33-37; EB-2, ET-1; see also EB-1, 3, 6, 15A at 17-18, 22).

Chest X-ray Evidence[2]

Exhibit No.	X-ray Date	Reading Date	Physician/ Qualifications	Interpretation
EB-5	8/3/93	8/3/93	DePonte B/R	0/0
EB-4	7/7/94	7/7/94	DePonte B/R	0/0
EB-9	12/15/98	7/14/00	Wheeler B/R	0/0; possible healed fracture
EB-10	12/15/98	7/14/00	Scott B/R	0/0
EB-14A, 32	12/15/98	8/1/00	Fino B	0/0
D-11	9/8/99	9/8/99	Forehand B	0/0
D-12	9/8/99	9/27/99	S. Navani B/R	0/0
D-23	9/8/99	12/6/99	Lauks B/R	0/0
D-23	9/8/99	11/26/99	Soble B/R	0/0; old rib fracture
D-28	10/1/99	1/2/00	Duncan B/R	0/0; scarring at left lung base
D-28	10/1/99	1/5/00	Soble B/R	0/0; scarring left lung base
D-28	10/1/99	1/11/00	Lauks B/R	0/0; nonspecific fibroatelectatic change in left lung
ET-1	3/27/00	7/10/00	Castle B	0/0
ET-2	3/27/00	10/19/00	Duncan B/R	0/0
ET-3	3/27/00	10/19/00	Lauks B/R	0/0
ET-4	3/27/00	10/18/00	Soble B/R	0/0
EB-2	6/26/00	6/26/00	A. Dahhan B	0/0
EB-2	6/26/00	7/6/00	Wheeler B/R	0/0; possible healed fracture

[2] The following abbreviations are used in describing the qualifications of the physicians: B-reader, “B”; board-certified radiologist, “R”. An interpretation of “0/0”signifies that the film was read completely negative for pneumoconiosis.

EB-7	6/26/00	7/6/00	Scott B/R	0/0
EB-11	6/26/00	7/20/00	Fino B	0/0
EB-8	7/11/00	7/13/00	DePonte B/R	0/0; mild hyperinflation which may indicate obstructive airways disease
EB-12	7/11/00	7/24/00	Wheeler B/R	0/0; healed fracture
EB-13	7/11/00	7/24/00	Scott B/R	0/0; possible healed fracture; linear artifact over left upper lung
EB-14	7/11/00	8/31/00	Fino B	0/0
EB-26	7/28/00	10/21/00	Wheeler B/R	0/0; probable healed fracture
EB-27	7/28/00	10/20/00	Scott B/R	0/0; possible healed fracture
EB-30	7/28/00	11/9/00	Fino B	0/0
EB-33	7/28/00	11/29/00	Castle B	0/1, s/s; dark film
EB-31	9/5/00	11/9/00	Fino B	0/0
EB-28	9/5/00	10/21/00	Wheeler B/R	0/0; probable healed fracture
EB-29	9/5/00	10/20/00	Scott B/R	0/0; underexposure; possible healed fracture
EB-23	9/5/00	9/5/00	Forehand B	0/0

Pulmonary Function Studies[3]

Exhibit No	**Test Date**	**Age/ Ht.**	**Physician**	**Conforming**	**FEV_1**	**FVC**	**MVV**	**Qualify**
D-7	9/8/99	54/69"	Forehand	Yes	1.93 2.08	3.48 3.59	68 75	Yes No
ET-1	3/27/00	55/69"	Castle	Yes	2.43 2.54	3.74 3.91	87	No No
EB-2	6/26/00	55/68.9"	Dahhan	Yes	2.04 2.14	3.24 3.32	71 72	Yes No

[3] The second set of values indicate post-bronchodilator studies.

EB-22	9/5/00[4]	55/69"	Forehand	Yes	2.19 2.42	3.97 4.19	76 85	No No

Arterial Blood Gas Studies[5]

Exhibit No.	Test Date	Physician	Conforming	pO_2	pCO_2	Qualifying
D-9	9/8/99	Forehand	Yes (D-10)	62 67	36 36	Yes No
ET-1	3/27/00	Castle	Yes	67.3	34.3	No
EB-2	6/26/00	Dahhan	Yes	76.4 82.9	38.7 38.9	No No
EB-24	7/28/00	Robinette	Yes	86	38.7	No
EB-21	9/5/00	Forehand	Yes	70 80	36 35	No No

Medical Reports/Opinions[6]

The record contains Claimant's Discharge Summary for his treatment at St. Mary's Hospital from January 11 through January 13, 1995, prepared by Dr. Barongan, whose credentials are not of record and are otherwise unavailable. (EB-6). The Claimant entered the hospital for a chief complaint of chest pain. Medical, family, surgical, and social histories were taken. It was noted that Claimant smoked approximately one-half pack of cigarettes per day, and Dr. Barongan advised him to quit smoking. Claimant's chest x-ray was negative, showing no signs of cardiopulmonary disease. Dr. Barongan noted

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[4] Dr. Forehand interpreted this pulmonary function study as indicating a partially reversible obstructive ventilatory pattern. He noted that there was evidence of hyperinflation and air trapping, oxygen saturation at rest was normal, and inspiratory and expiratory flow volume curves were not indicative of upper airway obstruction. Dr. Forehand stated that no previous studies were available for comparison. (EB-22).

[5] The second line of the values shown indicates post-exercise studies.

[6] The professional credentials of Drs. Forehand and Tholpady are not in evidence. However, this tribunal takes judicial notice that their relevant qualifications are disclosed on the worldwide web, American Board of Medical Specialties, Who's Certified Results, at http://www.abms.org. *See Maddaleni v. Pittsburgh & Midway Coal Mining Co.*, 14 B.L.R. 1-135 (1990).

that the Claimant had bronchitis, which was probably causing his chest pain.[7]

The record contains a treatment note from Dr. S.S. Tholpady, board-certified in internal medicine, and identified as Claimant's private physician, dated December 7, 1998. (EB-1, 3, 15A at 16-17; Tr.33-34). Dr. Tholpady stated that the Claimant "has no medical problems," worked twenty-five years in the coal mines, and was disabled because of back pain in the early part of 1997, but noted that the Claimant "smokes a pack or more of cigarettes daily for the past twenty-five years or more." Dr. Tholpady's diagnosis included cigarette addiction with possible emphysema, and chronic low back pain due to lumbar disc disease. Part of his "Plan" for the Claimant was for him to quit smoking completely and permanently.

Dr. J. Randolph Forehand, board-certified in pediatrics and allergy and immunology, examined the Claimant on September 8, 1999. (D-7, 8, 9). Dr. Forehand recorded a coal mine employment history of thirty years, lastly as a mine foreman for Two M Coal Company. Claimant reported that he had began smoking in 1974, and continued to smoke at a rate of one-half pack of cigarettes per day. Dr. Forehand recorded medical and family histories and Claimant's current medical complaints, which were significant for daily sputum, wheezing upon exertion, cough, dyspnea, "a lot" of daily non-exertional chest pain, and orthopnea. Dr. Forehand's examination of the Claimant included a chest x-ray, pulmonary function and arterial blood gas studies, and an EKG. Dr. Forehand interpreted the x-ray as completely negative. The pulmonary function study indicated an obstructive ventilatory pattern with no evidence of exercise induced hypoxemia (D-7). Based on his evaluation of the Claimant, Dr. Forehand diagnosed coal workers' pneumoconiosis[8] and chronic bronchitis with etiologies of coal dust exposure and cigarette smoking. He did not indicate how each etiologic factor contributed to the two diagnoses. Dr. Forehand opined that the Claimant had a severe respiratory impairment of a mechanical nature, and, that based on "the exercise test," Claimant would be unable to return to his last coal mining job because he was totally and permanently disabled. In regard to the etiology of the Claimant's respiratory impairment, Dr. Forehand stated the following, "It appears that more than one factor contributed to [the] impairment. Smoking cigarettes for 25 years is important; exposure to coal dust will also cause chronic airways disease and/or aggravate preexisting airway disease, a negative chest-x-ray notwithstanding." (D-8). Dr. Forehand suggested a CT scan to better define the nature of the Claimant's impairment.

Dr. James R. Castle, board-certified in internal medicine and the subspecialty of pulmonary diseases, examined the Claimant on March 27, 2000 and reviewed additional medical data including

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[7] Various medical records in evidence which are not relevant to Claimant's respiratory or pulmonary condition are not discussed. Such records include the diagnosis and treatment of his disabling back injury suffered in 1996, and various Social Security Administration evaluations which eventually resulted first in a determination dated November 6, 1997, that while Claimant's condition prevented him from doing the type of work he performed in the past, it did not prevent him from doing less demanding work, and, subsequently, in a determination dated June 18, 1998, that the Claimant had been continuously "disabled" since April 9, 1996 and that he was entitled to a period of disability commencing as of that date and to disability insurance.

[8] "Although “coal workers’ pneumoconiosis” may be used synonymously with pneumoconiosis in medical circles, the two terms are distinct legally.” *Hobbs v. Clinchfield Coal Co.*, 45 F.3d 819, 821 (4th Cir. 1995).

radiographic reports, and medical reports from Drs. D'Amato, Brasfield, and Forehand for his report of July 11, 2000. (ET-1). Dr. Castle recorded Claimant's work, social, past medical and family histories. Claimant reported that he began smoking at about age twenty or twenty-two and stopped smoking six months prior to the examination. However, Claimant also stated that he had smoked intermittently since then, and smoked two cigarettes the previous night. Claimant indicated that he smoked one-half pack of cigarettes per day when he was smoking regularly. Dr. Castle calculated Claimant's smoking history to be at least seventeen pack-years. Claimant informed Dr. Castle that he began working in the coal mines when he was eighteen years old and last worked in the mines in 1996 when he injured his back. The last job Claimant had in the coal mines was as a "working foreman," a job he held for over ten years.

Dr. Castle's examination included a chest x-ray, pulmonary function and arterial blood gas testing, and an EKG. The chest x-ray was interpreted by Dr. Castle as completely negative for pneumoconiosis. The pulmonary function testing revealed evidence of a mild airway obstruction without significant change after bronchodilator therapy, hyperinflation and gas trapping, and mildly reduced diffusing capacity which was essentially normal when corrected for alveolar volume. Claimant's resting arterial blood gases were normal. Based on the data obtained at the time of his examination, Dr. Castle opined that there was no evidence of coal workers' pneumoconiosis, but that the Claimant had tobacco smoke induced chronic bronchitis with secondary mild airway obstruction. Dr. Castle noted that Claimant's carboxyhemoglobin level of 7.5% was consistent with an ongoing smoking habit of at least one pack of cigarettes per day.

Upon reviewing the additional medical data submitted to him, Dr. Castle confirmed his findings from his own examination. He emphasized Claimant's thirty-four year smoking history as a significant risk factor for the development of Claimant's pulmonary symptoms. In support of his conclusion, Dr. Castle noted that Claimant never exhibited physical findings indicating the presence of an interstitial pulmonary process, all the radiographic evaluations were entirely normal, the physiologic studies showed evidence of a very mild degree of airway obstruction without restriction, gas trapping and hyperinflation, and the arterial blood gas studies showed fluctuations consistent with tobacco smoke induced chronic bronchitis. He found that there was significant improvement in Claimant's lung function since Dr. Forehand's September 1999 examination, which was consistent with changes associated with tobacco smoke induced chronic bronchitis, and inconsistent with coal workers' pneumoconiosis. Dr. Castle also noted that the arterial blood gases at the time of Dr. Forehand's study showed a mild degree of hypoxemia, but improved after exercise. This, he said, was inconsistent with a diagnosis of coal workers' pneumoconiosis because when coal workers' pneumoconiosis causes hypoxemia, it is not reversible with exercise. Dr. Castle concluded that the Claimant was not totally or permanently disabled by a pulmonary process arising from his coal mine employment, and that the Claimant retained the respiratory capacity to perform his usual coal mining employment duties. Dr. Castle also opined that it was possible that the Claimant was disabled as a result of his previous back injury, which was unrelated to his inhalation of coal dust. Dr. Castle opined that even if the Claimant were found to have radiographic evidence of coal workers' pneumoconiosis, his opinion regarding disability would not change because his opinion was predicated upon the Claimant's not having physiologic findings indicating impairment due to coal workers' pneumoconiosis.

Dr. Abdul K. Dahhan, board-certified in internal medicine and the subspecialty of pulmonary diseases, examined the Claimant on June 26, 2000, and reviewed additional medical records submitted to him consisting of Dr. Forehand's September 8, 1999 report and several x-ray interpretations of the Claimant's September 8 and October 1, 1999 films for his report of July 7, 2000. (EB-2). Dr. Dahhan recorded Claimant's work, social, family and medical histories. He noted that Claimant worked for thirty-five years in the mining industry, lastly as a foreman for eight years, and quit in 1996 due to a back injury. Dr. Dahhan recorded a smoking history of one-half pack of cigarettes per day that began when the Claimant was twenty-two years old and ended six months prior to the examination. He noted Claimant's history of daily cough with clear sputum, intermittent wheeze, dyspnea on exertion, and pain in the left chest. Dr. Dahhan's examination included a chest x-ray, pulmonary function and arterial blood gas testing, and an EKG. Dr. Dahhan noted normal arterial blood gas values before and after exercise, pulmonary function studies consistent with a mild mixed ventilatory defect, a completely negative chest x-ray, and a carboxyhemoglobin level of 5.1% indicating a smoking individual of one pack per day.

Dr. Dahhan opined that there was insufficient objective data to justify a diagnosis of coal workers' pneumoconiosis based on the mild obstructive abnormalities on clinical examination of the chest, normal blood gas exchange mechanisms at rest and after exercise, clear chest x-ray and mild obstructive ventilatory defect on pulmonary function study. He noted that while the Claimant had a mild abnormality in his respiratory capacity, it was not sufficient to render him totally or permanently disabled, and, accordingly, Dr. Dahhan concluded that the Claimant retained the physiological capacity to continue his previous coal mining work or job of comparable physical demand. Dr. Dahhan maintained that Dr. Forehand's arterial blood gas study results, which were not confirmed by his own results, were a "result of a superimposed illness or technical anomaly," none of which was related to coal dust induced hypoxemia. Dr. Dahhan concluded that even if the Claimant were found to have coal workers' pneumoconiosis, he would not be totally disabled from a respiratory standpoint. He also concluded that the Claimant did have a mild obstructive ventilatory defect. Dr. Dahhan opined that Claimant's statement regarding his smoking history was inconsistent with his elevated carboxyhemoglobin level value, which led him to question the validity of the Claimant's statement that he terminated his smoking habit six months prior to that examination. Dr. Dahhan ended his opinion by stating that the Claimant had coronary artery disease with a previous myocardial infarction and post lumbar disc surgery with complications, both of which are conditions of the general public and neither caused by, contributed to or aggravated by the inhalation of coal dust or coal workers' pneumoconiosis.

Claimant's Deposition[9]

The Claimant was deposed on July 24, 2000 in Norton, Virginia. (EB-15A). Claimant testified extensively regarding his work history, that he last worked in April 1996 as a foreman for Two M, and quit due to a back injury (EB-15A at 6-7, 28, 32). Claimant testified regarding his treatment by Dr. Brasfield for his back injury, status post lumbar laminectomy in 1996-97, and past angina (EB-15A at 15-16). He

[9] Claimant testified regarding his last employment apropos of the proper designation of the responsible operator, an issue deemed moot because his claim has been denied.

testified that Dr. Tholpady was his family doctor, but that he did not see a doctor for his breathing problems, nor was he on any medication for breathing problems (EB-15A at 16-17). Regarding his smoking history, Claimant stated that he had quit smoking five or six months prior to the deposition, but that he had smoked a few cigarettes since then. He testified that he began smoking in his twenties and that he smoked about one-half pack of cigarettes per day. (EB-15A at 17-18). Claimant testified regarding the various medical examinations he underwent for evaluation of his respiratory and pulmonary condition (EB-15A at 19-22).

Conclusions of Law and Discussion

To be entitled to benefits under Part 718, Claimant must establish by a preponderance of the evidence that (1) he suffers from pneumoconiosis; (2) the pneumoconiosis arose out of coal mine employment; (3) he is totally disabled; and (4) his total disability is caused by pneumoconiosis. *See Gee v. M.G. Moore & Sons*, 9 BLR 1-4 (1986). Failure to establish any of these elements precludes recovery under the Act.

Existence of Pneumoconiosis

For the purposes of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising from coal mine employment. This definition includes both medical, or "clinical," pneumoconiosis and statutory, or "legal", pneumoconiosis. See §718.201. Section 718.202(a) prescribes four bases for finding the existence of pneumoconiosis: (1) a properly conducted and reported chest x-ray; (2) a properly conducted and reported biopsy or autopsy; (3) reliance upon certain presumptions which are set forth in §§718.304, 718.305, 718.306; or (4) the finding by a physician of pneumoconiosis as defined in §718.201 which is based upon objective evidence and supported by a reasoned medical opinion.

Since the record contains no evidence of a biopsy or autopsy, the existence of pneumoconiosis cannot be established under section 718.202(a)(2). Since there is no evidence that Claimant suffers from complicated pneumoconiosis, the presumption set forth in section 718.304 is inapplicable. Since the claim was filed after January 1, 1982, and since this is not a survivor's claim, the presumptions set forth in sections 718.305 and 718.306 are inapplicable as well.

The record contains no radiographic evidence of pneumoconiosis. All ten x-rays were interpreted as completely negative for pneumoconiosis by the reviewing physicians, the majority of whom were dually qualified board-certified radiologists and B-readers. Accordingly, Claimant has not established the existence of pneumoconiosis under 718.202(a)(1).

Dr. Forehand was the only physician who opined that the Claimant had pneumoconiosis. However, his opinion is entitled to little weight because it does not rise to the level of a reasoned opinion. It is also outweighed by the contrary opinions of record. Dr. Forehand diagnosed the Claimant with coal workers' pneumoconiosis and chronic bronchitis, but did not document the clinical findings, data, observations, and

facts which he presumably relied upon in making those diagnoses. Dr. Forehand also stated that the Claimant had a significant respiratory impairment, but did not attribute it to Claimant's coal mine employment. Instead, he explained that more than one factor contributed to that impairment, stating that Claimant's twenty-five year smoking history was important and that exposure to coal dust "will also" cause or aggravate chronic airways disease. Dr. Forehand never stated whether Claimant's coal dust exposure contributed to his chronic airways disease, and suggested that a CT scan of the Claimant's chest would "better define the nature of impairment." (D-8). Accordingly, Dr. Forehand's undocumented opinion does not support a finding of pneumoconiosis. *See Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987); *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989) (en banc); *Lango v. Director, OWCP*, 104 F.3d 573, 577 (3d Cir. 1997) (The mere statement of a conclusion by a physician, without any explanation of the basis for that statement does not take the place of required reasoning.)

The contrary opinions of Drs. Castle and Dahhan are well-reasoned, documented, and fully supported by the x-ray and physiologic evidence. *Perry v. Director, OWCP*, 9 BLR 1-1 (1986). Both physicians considered Claimant's extensive coal mine employment history and cigarette smoking habit, which they agreed was ongoing and understated by the Claimant. Drs. Castle and Dahhan not only explained how they ruled out the presence of pneumoconiosis, but they both explained how Dr. Forehand's examination of the Claimant failed to yield clinical data consistent with a finding of pneumoconiosis. Finally, both Dr. Castle and Dr. Dahhan had the opportunity to consider substantial evidence of record including Dr. Forehand's examination and numerous x-ray interpretations, along with medical data from their own examinations of the Claimant, thus providing them with a broad base from which to draw their conclusions. (ET-1; EB-2). Accordingly, this tribunal accords their opinions substantial weight, and finds the medical opinion evidence does not establish of the existence of pneumoconiosis under §718.202(a)(4). And, upon consideration of all the medical evidence bearing on the existence of pneumoconiosis, this tribunal finds that the Claimant has failed to establish the existence of pneumoconiosis pursuant to §718.202. *See Island Creek Coal Co. v. Compton*, 211 F.3d 203, 2000 WL 524798 (4th Cir. 2000); *Penn Allegheny Coal Co. v. Williams*, 114 F.2d 22, 24-25 (3d Cir. 1997).

Causation

In addition to establishing the existence of pneumoconiosis, a claimant must also establish that his pneumoconiosis arose, at least in part, out of his coal mine employment. Pursuant to §718.203(b), a claimant is entitled to a rebuttable presumption of a causal relationship between his pneumoconiosis and his coal mine employment if he worked for at least ten years as a coal miner. In the instant case, Claimant established 22.89 years of coal mine employment. Thus, had he established the existence of pneumoconiosis, he would have also been entitled to the rebuttable presumption that his pneumoconiosis arose from his coal mine employment under the provisions of §718.203(b). But, because he has not established the existence of pneumoconiosis, the issue is moot.

Disability Due to Pneumoconiosis

To establish total disability, Claimant must prove that he is unable to engage in either his usual coal mine work or comparable and gainful work as defined in §718.204. Section 718.204(b)(2) provides the criteria for determining whether a miner is totally disabled. These criteria are: (1) pulmonary function tests qualifying under applicable regulatory standards; (2) arterial blood gas studies qualifying under applicable regulatory standards; (3) proof of pneumoconiosis and cor pulmonale with right sided congestive heart failure; or (4) proof of a disabling respiratory or pulmonary condition on the basis of the reasoned medical opinion of a physician relying upon medically acceptable clinical and laboratory diagnostic techniques. If there is contrary evidence in the record, all the evidence must be weighed in determining whether there is proof by a preponderance of the evidence that the miner is totally disabled by pneumoconiosis. *Shedlock v. Bethlahem Mines. Corp.*, 9 B.L.R. 1-95 (1986).

Under §718.204(b)(2)(i), all ventilatory studies of record, both pre-and post-bronchodilator , must be weighed. *See Strake v. Ziegler Coal Co.,* 3 B.L.R. 1-136 (1981). Of the four pulmonary function tests performed between September 1999 and September 2000, only two pre-bronchodilator tests yielded qualifying results (D-7; EB-2). Claimant's most recent pulmonary function test was entirely non-qualifying (EB-22). Therefore, given that only two pre-bronchodilator studies produced qualifying values, and all four post-bronchodilator studies yielded non-qualifying values, which is significant in that it militates against total disability under applicable regulatory standards, the preponderance of the pulmonary function study evidence does not establish total disability pursuant to § 718.204(b)(2)(I). *See Phillips v. Jewell Ridge Coal Co.*, 825 F.2d 408, 10 B.L.R. 2-160 (4th Cir. 1987); *see also, Defore v. Alabama By-products Corp.*, 12 B.L.R. 1-27 (1988); *cf. Adkins v. Secretary, HHS*, 755 F.2d 931 (6th Cir. 1985).

There were five blood gas studies performed between September 1999 and September 2000. The post-exercise results in the initial study and the four most recent studies yielded non-qualifying values, both before and after exercise. Therefore, Claimant has not established total disability by a preponderance of the evidence pursuant to §718.204(b)(2)(ii). Since there is no evidence of cor pulmonale with right-sided congestive heart failure, Claimant has not proved total disability pursuant to Section 718.204(b)(2)(iii).

Finally, the medical opinions of the physicians who examined Claimant and reviewed additional medical evidence also fail to establish that the Claimant is totally disabled by a respiratory or pulmonary impairment. §718.204(b)(2)(iv). While many physicians of record opined that the Claimant was totally disabled by his back injury, only Dr. Forehand opined that the Claimant was totally and permanently disabled by his obstructive respiratory impairment. (D-8). Dr. Forehand based his finding of total disability on the "exercise test" he administered to the Claimant during his examination. However, Dr. Forehand did not mention in his report that the Claimant completed an exercise test, other than the arterial blood gas study post exercise, which yielded non-qualifying values, and which Dr. Forehand described as indicating "no evidence of exercise-induced hypoxemia" and "no metabolic disturbance." (D-7, 8). Dr. Forehand's opinion regarding total disability is, therefore, unreasoned and undocumented, and, thus, this tribunal accords his opinion little weight. *See Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987); *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989) (en banc).

The contrary opinions of Drs. Castle and Dahhan are documented and supported by the objective data, which they agreed produced values indicative of a mild obstructive ventilatory impairment which was insufficient to render the Claimant totally disabled. (ET1; EB-2). Both physicians understood the nature of Claimant's last coal mine employment as a working foreman, and both had the opportunity, unlike Dr. Forehand, to review extensive specified medical evidence in reaching their conclusions. For these reasons, this tribunal accords their opinions increased weight and finds them more persuasive than Dr. Forehand's. Accordingly, this tribunal finds total disability has not been established by the medical opinions of record under §718.204(b)(2)(iv), and, therefore, the Claimant has failed to establish this element of the claim.

Total Disability Due to Pneumoconiosis

To establish entitlement, a claimant must prove by a preponderance of the evidence that he is totally disabled due to pneumoconiosis. A miner is considered totally disabled due to pneumoconiosis if pneumoconiosis is a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment. §718.204(c)(1). Pneumoconiosis is a "substantially contributing cause" of the miner's disability if it has a material adverse effect on the miner's respiratory or pulmonary condition, or it materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment. *Id.*

In this case, the preponderance of the evidence did not establish that Claimant has pneumoconiosis, that his pneumoconiosis arose out of his coal mine employment, or that he is totally disabled. Therefore, the issue of whether the Claimant is totally disabled due to pneumoconiosis is moot. Notwithstanding, Dr. Forehand, the only physician who opined that the Claimant had pneumoconiosis and was totally disabled, did not opine that the Claimant was totally disabled due to pneumoconiosis. While Dr. Forehand stated that exposure to coal dust will cause chronic airways disease, he did not opine that Claimant's allegedly disabling chronic airways disease was caused by coal dust inhalation, and merely suggested the need for a CT scan to further define the nature of Claimant's impairment. (D-8). Accordingly, even if the Claimant had established the other elements of entitlement, he would not have established total disability due to pneumoconiosis.

Attorney's Fees

The award of an attorney's fee under the Act is permitted only if benefits are awarded. Since benefits are not awarded in this case, the Act prohibits the charging of any fee for representation in pursuit of the claim before this tribunal.

ORDER

The claim of Roy E. Greene for black lung benefits under the Act is hereby denied.

A
EDWARD TERHUNE MILLER
Administrative Law Judge

Washington, D.C.

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 (thirty) days from the date of this Decision by filing a Notice of Appeal with the **Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601.** A copy of this notice must also be served on Donald S. Shire, Associate Solicitor, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.